STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515179	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Center	80 Maddex Drive Shepherdstown, WV 25443

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 50795 Based on observation and interview, the facility failed to uphold the residents' right to be treated with dignity and respect by leaving urinary catheter bags uncovered and prominently displayed. Resident Identifiers: Residents #28 and #58. Facility Census: 59. Findings Include: a) Resident #28 On 03/10/25, at approximately 1:35 PM, Resident #28 was observed in bed. The resident's catheter bag, which was uncovered and half full of urine, was seen dangling off the foot of the bed in plain view of anyone passing by. At approximately 1:37 PM on 03/10/25, Licensed Practical Nurse (LPN) #38 confirmed that the catheter bag needed to be covered. She stated that she would cover the catheter bag immediately. 50801 b) Resident #58 On 03/10/2025 at 11:03 AM, It was observed Resident #58 in his wheelchair rolling down the hall with his catheter bag in his lap. The catheter bag did not have a bag cover. In an interview with Resident #58, on 03/10/2025 at 11:05 AM, he stated he has never been offered a cover for his catheter bag and would like to have one. In an interview with RN #25 on 03/10/2025, at approximately 11:10 AM, he acknowledged Resident # 58 did not have a cover for his catheter bag.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	515179	A. Building B. Wing	03/18/2025

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 42120 50795 Based on observation and interview, the facility failed to ensure that residents had the opportunity to exercise autonomy over important aspects of her life such as choice regarding waking time and morning care. Resident Identifier: Residents #50 and #52 Facility Census: 59. Findings Include: a) Resident #52 During an interview with Resident #52, on 03/10/25, at 1:51 PM, she expressed her preference for waking up early and having her bed made and morning care completed before breakfast. She noted that she does not receive morning care until after 10:00 AM. A family member present during the interview stated that they have raised this issue with the nursing staff multiple times, but no action has been taken. The resident also mentioned that her roommate receives morning care around 7:45 AM each day, while she does not receive assistance until much later. Observations on 03/11/25 revealed that AM care was provided to Resident #52 at approximately 10:20 AM. During an interview with the Director of Nursing (DON) on 03/10/25, at 10:35 AM, the DON confirmed that the resident has the right to receive morning care at a time of their choosing. The DON stated that she would follow up and ensure that the staff are aware of Resident #52's request to have her bed made and morning care completed before breakfast. A review of the residents Care Plan on 03/11/25 at approximately 3:55 PM revealed the following: FOCUS Provide resident/patient with opportunities for choice Date Initiated: 02/07/25 Created on: 11/27/24 Revision on: 02/07/25 GOAL Resident requires assistance for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: Recent hospitalization , fall at home with (continued on next page)

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	515179	A. Building B. Wing	03/18/2025

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fracture, Date Initiated: 02/07/25 Created on: 11/27/24 Revision on: 02/19/25 INTERVENTIONS: Resident prefers to get AM care early, around 7AM. Date Initiated: 03/11/25 Created on: 03/11/25 Created by: DON Further observations and an interview on 03/12/25 at 10:43 AM revealed that the resident had not received her morning care until approximately 10:00 AM. During an interview with Consulting Administrator (CA) #100 on 03/12/25, at approximately 11:05 AM, CA #100 stated that she would ensure the resident's wishes regarding morning care would be honored, after being notified of the resident's complaint. An interview with Resident #52 and a family member on 03/17/25 at approximately 9:00 AM, revealed that the resident's bed had been made and morning care had been completed before breakfast. b) Resident #50 During an observation and interview with Resident #50 on 03/10/25 at 10:18 AM, she was upset about the staff not making her bed. She was trying to get it made and get dressed herself. She stated that she likes getting ready for the day early and having her bed made. She continued to say that staff tell her that they are helping other residents, and no one comes to help her until later in the day. A record review revealed resident #50's preferences for her morning routine were not documented. On 03/11/25 at 10:37 AM during an interview, Resident #50 was up and dressed with her bed made. She stated that she got herself ready and made her own bed. On 03/11/24 at 12:49 PM during an interview the Administrator verified there were no morning preferences documented. She continued to state that instead of looking for her preferences, I will have activities staff go get her preferences on her daily routine now.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 50801 The facility failed to post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. Random opportunity for discovery. Census 59 Findings included: a) 03/17/25 4:50 PM first observation: A sign located at the receptionist window in the lobby stated that survey results are located on the shelf under the television. However, the state survey results were not located on the book shelf nor anywhere else in the lobby during this observation. b) 03/18/25 11:25 AM second observation: The state survey results were not located on the bookshelf nor anywhere else in the lobby during this observation. c) In an interview with the Administrator 03/18/25 at 11:30 AM she did not find the survey book on the bookshelf and went to locate it. She came back and stated she found it in the business office.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50795 Based on observation and staff interview, the facility failed to secure and protect residents' personal and medical information. Specifically, private information was not safeguarded and was found in a clear acrylic wall file located in the residents' hallway. This was a random opportunity for discovery. Facility Census: 59. Findings Include: On 03/18/25 at approximately 8:50 AM, a random opportunity for discovery found multiple documents with resident's identifiable health information in an acrylic wall file holder mounted on the wall outside the nursing office on the 300 wing of the facility. A review of the documents on 03/18/25 at 9:15 AM revealed the following: a) Resident names, Room numbers, Diagnoses, Code status, and Vital signs for twenty-nine (29) residents. b) Prescription information for Resident #221. A new resident admitted on [DATE]. c) Medication listings for thirty-one (31) residents d) A controlled drug administration record for Resident #52. The documents also included Shift Change Controlled Substance Inventory Count Sheets for A Wing from 03/10/25 to 03/14/24. At approximately 9:20 AM on 03/18/25, during an interview with the Director of Nursing (DON), she confirmed that the documents had been placed in the file holder. However, she noted that the documents were placed with the blank side facing up, making the information on them not readily visible to anyone. The Market Clinical Advisor (MCA) #101 was informed at 9:25 AM that documents had been left unsecured in a heavily trafficked hallway, making them accessible to anyone.

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	515179	A. Building B. Wing	03/18/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50551 50795 Based on observation and interviews, the facility failed to maintain a homelike environment by not providing housekeeping and maintenance services to ensure that residents' rooms were being kept in a clean and sanitary condition. Room Identifiers: #103, #104, #108, #110, #302, #304, #307B, #401, #402, #404 #408, 400 Wing hallway, and Shower Room. Resident Identifier: #47. Facility Census: 59. Findings Include: a) Observation of the facility interior upon survey entry on 03/10/25 at 5:30AM: room [ROOM NUMBER] had approximately 3 foot section of section of unfinished drywall above heads of beds The 400 hallway above the resident's room doors had rips in the wall paper borders room [ROOM NUMBER], unfinished dry wall patches on the wall above the head of both resident's beds - Bathroom between rooms [ROOM NUMBERS] had a yellowish stain around base of toilet, and over-flowing trash can. In an interview on 03/10/25 at approximately 5:45 AM, with RN employee identifier #25, he acknowledged the unfinished drywall on the wall in room room [ROOM NUMBER] above the head of both resident's beds. During an interview with RN #25 on 03/10/25 at 6:00AM, he acknowledged the trash can in the shared bathroom between rooms [ROOM NUMBERS] was overflowing with trash on the floor. He stated the trash can should have been emptied and the floor should have been cleaned. In an interview with RN #25 on 03/10/25 at 6:10 AM, he acknowledged in 408 there were unfinished patches of drywall a four (4) foot long by (3) inch wide, unfinished section of drywall behind the bathroom door - unfinishedhe stated he would report all the resident rooms in need of repair on the 400 hall. b) Further observation of the facility interior on 3/10/2025, between 8:45AM and 11:25AM: Resident room [ROOM NUMBER]: During an inspection on 03/10/25 at approximately 8:45 AM, the bathroom in room [ROOM NUMBER] revealed that the wall behind the commode was bulging, with brown substances in the drywall. Resident room [ROOM NUMBER]: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an inspection on 03/10/25 at approximately 8:49 AM, the bathroom in room [ROOM NUMBER] revealed a toilet bowl with brown spots in it, and the wall behind the commode was bulging, with brown substances in the drywall. RN #8 confirmed that the bathroom needed to be cleaned, and maintenance notified. Resident room [ROOM NUMBER]: During an inspection on 03/10/25 at approximately 8:55 AM, the bathroom in room [ROOM NUMBER] revealed cracked tile and a brown substance around the base of the commode. Resident room [ROOM NUMBER]: During an inspection on 03/10/25 at approximately 8:55 AM, the bathroom in room [ROOM NUMBER] revealed cracked tile and a brown substance around the base of the commode. Resident room [ROOM NUMBER]: During an inspection on 03/10/25 at approximately 9:09 AM, the bathroom in room [ROOM NUMBER] revealed a plastic container with a brown substance in it. In addition the wall behind the commode was bulging, with brown substances in the drywall. RN #8 confirmed that the plastic container should not have been left in the bathroom. RN #8 contacted housekeeping to remove the container. She also stated that maintenance would be notified about the bulging wall. Resident room [ROOM NUMBER]: During an inspection on 03/10/25 at approximately 9:15 AM, the bathroom in room [ROOM NUMBER] revealed that the wall behind the commode was bulging, with brown substances in the drywall. Shower Room: During an inspection of the shower room on 03/11/25 at approximately 11:25 AM, ceiling tiles with a brown substance were observed. RN # 8 confirmed that the ceiling tiles needed to be changed. During a walk-through with the Maintenance Director (MD) #56 on 03/17/25 at approximately 11:30 AM, MD # 56 created a punch list and confirmed that the bathrooms in Rooms #103. #104, #108, #110, #302, and #308 needed to be repaired. In addition, MD #56 also confirmed that the ceiling tiles in the shower room would have to be replaced. c) Resident room [ROOM NUMBER]B: Resident #47 reported their room had spots on the ceiling, and had requested that the ceiling be painted last October (2024). On 03/11/25 at 10:00 AM, a review of resident council meeting minutes dated 10/01/24- under Maintenance category revealed 307-B would like the ceiling painted. Resident council meeting minutes dated for 03/04/25 under Maintenance category revealed Resident #47 (307-B) requested her ceiling be painted. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/11/25 at 12:00 PM during resident council meeting, Resident # 47 reported that she has requested that her ceiling be painted due to dark spots on the ceiling. On 03/11/25 at 2:09 PM observation of residents ceiling in her room showed there were several dark spots on the ceiling. On 03/11/25 at 3:44 PM during an interview with the Maintenance Director in regards to the ceiling spots in Resident #47's room. His initial response was She's on my list. He stated that maintenance tries to keep those spots painted. He then went on to state that he was not aware that the ceiling needed painted but was aware the walls in her room did. 50801

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	515179	A. Building B. Wing	03/18/2025

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 50801 Based on policy review, record review, and staff interview, the facility failed to ensure that all written grievance decisions included the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. This was a random opportunity for discovery. Resident identifier: #218. Facility census: 59. a) Resident #218: On 03/17/25 at 03:45 PM, during record review, a grievance form dated 4/10/2024 was not completed for Resident #218. Per the facility's Grievance Policy, the grievance officer will oversee grievances through conclusion leading any necessary investigations by the facility, issuing written decisions to the patient, and coordinating with state and federal agencies. In an interview with the Administrator on 3/17/25, at 2:44 PM, she acknowledged the grievance form for Resident #218 was not completed nor logged into the grievance log but would check for a completed copy of the grievance form. In an interview on 03/17/25, at approximately 3:40 PM, the administrator stated she has not found a completed copy of the grievance form.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 42120 Based on observation, staff interviews, electronic medical record and Operation Policy the facility failed to follow written policy, thorough investigating and reporting to proper agencies of injury of unknow origin and neglect. This is true of two (2) of six (6) residents reviewed for abuse. Resident identifier: #55 and #36. Facility census: 61. Findings include: a) Resident #55 An observation and interview with Resident #55 on 03/10/25 at 8:49 AM revealed a large bruise on her left upper arm. She stated that she did not know where she got it. During an interview on 03/10/25 at 9:01 AM the Director of Nursing (DON) stated she was unaware of the bruise on Resident #55's left upper arm. She continued to state that she would get the bruise check. During an interview on 03/17/25 2:50 PM the DON stated that she had the Nurse Practitioners (NP) assess Resident #55's left upper arm. A record review revealed the Nurse Practitioners skin assessment on 03/11/25: Skin: Old bruises on her hands that were present when she arrived, likely due to previous IV insertion sites. She appears to have new bruising on her upper arms of unknown cause. She denies pain. Transcribed as written. During an interview on 03/17/25 at 3:20 PM the DON confirmed she did not report or investigate the injury of unknown origin. The DON verified that she should have investigated and reported the incident per policy. Record review of the facility's policy titled, Abuse, showed: -Injuries of unknown source- are defined as an injury with both of the following conditions. -The source of the injury was not observed by any person, or the source of the injury could not be explained by the patient; and -The Injury is suspicious because of the extent of the injury or the location of the injury. -Staff will identify events such as bruising of patients, occurrences, patterns and trends that may constitute abuse. -Injuries of unknown origin will be investigated to determine if abuse or neglect is suspected. (continued on next page)

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	515179	A. Building B. Wing	03/18/2025

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Report allegations to appropriate state and local authorities involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of patient property not later than two (2) hours after the allegation is made if it does result in serious bodily injury. -Report allegations to appropriate state and local authorities involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of patient property not later than (24) hours after the allegation is made if it does not result in serious bodily injury. - 50795 b) Resident #36 The facility failed to follow its abuse and neglect policy by not reporting an allegation of neglect to the Office of Health Facility Licensure and Certification (OHFLAC) timely. A review of a complaint submitted on 09/04/24 to OHFLAC by a family member stated that Resident #36 had developed pressure ulcers at the facility. During a phone interview on 03/13/25, at 9:15 AM, a family member of Resident #36 reported that she had visited the resident on September 2, 2024. During this visit, RN #52 brought to her attention the presence of new Moisture Associated Skin Damage (MASD) on Resident #36's buttocks. The family member also mentioned that Resident #36 had told her she was not receiving many baths, and that facility staff very rarely offered her a bath. Because of these concerns, the family member filed a complaint with the facility, with Adult Protective Services (APS), and the Office of Health Facility Licensure and Certification (OHFLAC) on September 4, 2024. Record review revealed that after an investigation by APS in February 2025, the facility completed a grievance/Concern form on 02/19/25 which stated that a complaint was filed over the APS hotline in September of 2024. A review of the grievance log for February 2025 on 03/17/25 at 11:25 AM, revealed no entry for Resident #36. Further review revealed that the facility had initiated an investigation into the complaint in February 2025. A review of the investigative documents on 03/12/25, at approximately 9:20 AM revealed that the facility had failed to submit reports to OHFLAC regarding the allegation of neglect and the subsequent investigation. A review of the investigative documents submitted by the facility showed an email message to APS from the facility Social Worker (SW) dated 02/20/25 at 12:51 PM which stated the following: I tried to fax all the forms, but it has been a challenge. Please view all the forms here. (continued on next page)

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	515179	A. Building B. Wing	03/18/2025

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review revealed two other emails from an APS worker to the SW which stated the following: On 02/202/4 at 1:09 PM APS responded stating: Thank you, I got it. I got a very big fax. Thank you again! On 02/20/25 at 3:07 PM another email from an APS worker to the SW stated the following: Thank you! Then you are good! I will close this case out! Thanks for the help! Much appreciated! On 03/12/24 at approximately 1:15 PM, the Market Clinical Advisor (MCA) #101 requested the investigative records back, stating, We need to report this. On 03/18/25 at approximately 10:00 AM, upon requesting the investigative documents for review, it was revealed that the facility had submitted an Initial Report to OHFLAC on 03/17/25 at 6:55 PM. The facility had noted a response to the question: What was reported? During the process of looking at investigation for survey, there was a review for [Resident] regarding skin and bathing.

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	515179	A. Building B. Wing	03/18/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 42120 50795 Based on observation, staff interview, and operation policy, the facility failed to report alleged violation related to, neglect, or abuse, and report the results of all investigation to the proper authorities within prescribe time frames. This is true for two (2) of six (6) allegations of abuse. Resident identifier: #55 and #36. Facility census: 61. Findings include: a) Resident #55 An observation and interview with Resident #55 on 03/10/25 at 8:49 AM revealed a large bruise on her left upper arm. She stated that she did not know where she got it. During an interview on 03/10/25 at 9:01 AM the Director of Nursing (DON) stated she was unaware of the bruise on Resident #55's left upper arm. She continued to state that she would get the bruise check. During an interview on 03/17/25 2:50 PM the DON stated that she had the Nurse Practitioners (NP) assess Resident #55's left upper arm. A record review revealed the Nurse Practitioners skin assessment on 03/11/25: Skin: Old bruises on her hands that were present when she arrived, likely due to previous IV insertion sites. She appears to have new bruising on her upper arms of unknown cause. She denies pain. Transcribed as written. During an interview on 03/17/25 at 3:20 PM the DON confirmed she did not report or investigate the injury of unknown origin. The DON verified that she should have investigated and reported the incident. Record review of the facility's policy titled, Abuse, showed: -Injuries of unknown source- are defined as an injury with both of the following conditions. -The source of the injury was not observed by any person, or the source of the injury could not be explained by the patient; and -The Injury is suspicious because of the extent of the injury or the location of the injury. -Staff will identify events such as bruising of patients, occurrences, patterns and trends that may constitute abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Injuries of unknown origin will be investigated to determine if abuse or neglect is suspected. -Report allegations to appropriate state and local authorities involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of patient property not later than two (2) hours after the allegation is made if it does result in serious bodily injury. -Report allegations to appropriate state and local authorities involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of patient property not later than (24) hours after the allegation is made if it does not result in serious bodily injury. b) Resident #36 The facility failed to report an allegation of neglect to the Office of Health Facility Licensure and Certification within the required timeline A review of a complaint submitted on 09/04/24 to OHFLAC by a family member stated that Resident #36 had developed pressure ulcers and was not getting baths at the facility. During a phone interview on 03/13/25, at 9:15 AM, a family member of Resident #36 stated that she visited the resident on September 2, 2024. During her visit, RN #52 pointed out new Moisture-Associated Skin Damage (MASD) on the resident's buttocks. The family member also mentioned that Resident #36 reported she was not receiving many baths, indicating that facility staff very rarely offered her a bath. The family member further revealed that she filed a complaint with Adult Protective Services (APS) and the Office of Health Facility Licensure and Certification (OHFLAC) on September 4, 2024. Following an investigation by APS, the facility had performed an investigation. A record review of the investigative documents on 03/12/25 at approximately 9:20 AM revealed that the facility had not submitted reports to OHFLAC regarding the allegation of neglect and the follow-up investigation. A review of the investigative documents submitted by the facility showed an email message to APS from the facility Social Worker (SW) dated 02/20/25 at 12:51 PM which stated the following: I tried to fax all the forms, but it has been a challenge. Please view all the forms here. Further review revealed two other emails from an APS worker to the SW which stated the following: On 02/202/4 at 1:09 PM APS responded stating: Thank you, I got it. I got a very big fax. Thank you again! On 02/20/25 at 3:07 PM another email from an APS worker to the SW stated the following: Thank you! Then you are good! I will close this case out! Thanks for the help! Much appreciated! (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515179	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Center	80 Maddex Drive Shepherdstown, WV 25443

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/12/25 at approximately 10:55 AM Resident #36 was observed sitting in her wheelchair near the lounge area. An attempt to interview resident was unsuccessful, because resident was sleepy an mumbled responses that were unintelligible. On 03/12/24 at approximately 1:15 PM, the Market Clinical Advisor #101 requested the investigative records back, stating, We need to report this. On 03/18/25 at approximately 10:00 AM, upon requesting the investigative documents for review, it was revealed that the facility had submitted an Initial Report to OHFLAC on 03/17/25 at 6:55 PM. The facility had noted a response to the question: What was reported? During the process of looking at investigation for survey, there was a review for [Resident] regarding skin and bathing. Based on the record review, the facility failed to report the allegation to the Office of Health Facility Licensure and Certification (OHFLAC).

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	515179	A. Building B. Wing	03/18/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 42120 Based on observation, staff interview, and operation policy, the facility failed to take actions to investigate a large bruise of unknow origin and neglect. This was a random opportunity for discovery. Resident identifier #55. Facility Census 61. Findings include: a) Resident #55: An observation and interview with Resident #55 on 03/10/25 at 8:49 AM revealed a large bruise on her left upper arm. The resident stated that she did not know where she got it. During an interview on 03/10/25, at 9:01 AM, the Director of Nursing (DON) stated she was unaware of the bruise on Resident #55's left upper arm. She continued to state that she would get the bruise checked. During an interview on 03/17/25, at 2:50 PM, the DON stated that she had the Nurse Practitioners (NP) assess Resident #55's left upper arm. A record review revealed the Nurse Practitioners skin assessment on 03/11/25: Skin: Old bruises on her hands that were present when she arrived, likely due to previous IV insertion sites. She appears to have new bruising on her upper arms of unknown cause. She denies pain. Transcribed as written. During an interview on 03/17/25 at 3:20 PM the DON confirmed she did not report or investigate the injury of unknown origin. The DON verified that she should have investigated and reported the incident per policy. Record review of the facility's policy titled, Abuse, revealed: - Injury of unknown source- are defined as an injury with both of the following conditions. - The source of the injury was not observed by any person, or the source of the injury could not be explained by the patient; and - The Injury is suspicious because of the extent of the injury or the location of the injury. - Staff will identify events such as bruising of patients, occurrences, patterns and trends that may constitute abuse. - Injuries of unknown origin will be investigated to determine if abuse or neglect is suspected. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515179	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Center	80 Maddex Drive Shepherdstown, WV 25443

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Report allegations to appropriate state and local authorities involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of patient property not later than two (2) hours after the allegation is made if it does result in serious bodily injury. - Report allegations to appropriate state and local authorities involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of patient property not later than (24) hours after the allegation is made if it does not result in serious bodily injury.

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	515179	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Center	80 Maddex Drive Shepherdstown, WV 25443

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50551 Based on record review and staff interview the facility failed to accurately document resident's discharge status in Minimum Data Set assessment (MDS). The assessment must represent an accurate picture of the resident's status during the observation period of the MDS. Resident #62. Findings included: a) Resident #62: An observation on 03/12/24, at 10:58 AM, revealed MDS dated [DATE], Section A, Question A2105 Discharge Status. entered code 4 (four) Short-term General hospital (acute hospital, IPPS). An observation on 03/12/25, of a Social Services Note dated 12/23/24, at 4:40PM, stated Resident's daughter arrived at facility this date and states that she is picking resident up to take him home. She reports that she has arranged for home health services and medical appointment with VA Medical Center. During an interview with MDS Coordinator #54 on 03/12/25, at approximately 12:55 PM, in regards to MDS question A2105 Discharge Status 04.Short-Term General Hospital (acute hospital, IPPS) dated 12/24/24, MDS Coordinator #54 revealed that the MDS was incorrectly marked in error as discharge to hospital and should have been appropriately marked as discharged to home.

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	515179	A. Building B. Wing	03/18/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 42120 Based on observation, record review, resident, staff interview. The facility failed to assist dependent Residents with activities of daily living (ADL's) in accordance with the Residents assessed needs for care. This is true for one (1) of four (4) residents reviewed for ADL care. Resident Identifiers: #50. Facility census: 61. Findings Included: a) Resident #50 showers During an interview and observation on 03/10/25 at 10:20 AM Resident #50 stated that she doesn't get her showers or baths as ordered or her preference. She continued to say that I don't like not having a shower when I get visitors. Her hair was observed to be very oily during this interview. A review of Resident #50's ADL documentation found that there was only one (1) shower on 02/21/25 and two bed baths noted on 02/11/25 and 02/14/25 given in 30 days. During an Interview on 03/11/25, at 12:25AM, the Administrator verified there was no documentation that Resident #50 received showers as scheduled.

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	515179	A. Building B. Wing	03/18/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50795 Based on observation, interview, and record review, the facility failed to implement protocols ensuring that staff conducted incontinence assessments for dependent residents and provided incontinence care at the required intervals throughout the day. Resident Identifier: #51. Facility Census: 59. Findings Include: a) Resident #51 Observation, interview and record review revealed that a dependent resident was not being provided incontinence care in a timely manner. During an interview on 03/10/25, at approximately 1:15 PM, the Medical Power of Attorney (MPOA) for Resident #51 stated that she visits the resident every day. She mentioned that Resident #51 is incontinent and noted that the facility staff has failed to assess the resident for incontinence at regular intervals. Additionally, she indicated that the resident experiences fecal incontinence, and she often has to clean him up upon her arrival at the facility. Record review revealed documentation that the resident was assessed for incontinence regularly. On 03/12/25, at approximately 11:25 AM, Nursing Assistant (NA) #17, who was assigned to care for Resident #51, was interviewed. During the interview, Market Clinical Advisor (MCA) #101, who was present, noted that the documentation for incontinence assessments was not available in Point Click Care (PCC). However, she stated that it could be accessed on the tablets used by the nursing assistants to document their tasks. MCA #101 instructed NA #17 to provide the necessary information. When questioned about the assessments for Resident #51, NA #17 stated that she had checked on the resident at 7:00 AM on 03/12/25. Documentation on the tablet confirmed that Resident #51 was assessed at that time. However, no further assessments were recorded afterward. When asked how often residents should be checked, NA #17 replied that checks should occur every 2 hours. NA #17 also confirmed that Resident #51 had not been checked again after 7:00 AM. During an interview with the DON on 03/12/25 at 12:16 PM, the DON confirmed that residents should be checked at least every two hours, and stated that the NAs would be educated.

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	515179	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42120 Based on observation and interviews, the facility failed to ensure the resident environment, over which they had control, was as free from accident hazards as possible in regards to water temperatures. This was a random opportunity for discovery. Room Identifiers: Rooms #101, #107, #202, and #302. Facility census:59. Findings Include: a) Resident #1 During an interview on 03/10/25, at 9:13 AM, Resident #1 stated that the water is too hot for her. She stated that she has never been burnt but must ask the staff to make the water temperature cooler. During an inspection of Resident #1s sink water temperature, this surveyor had to pull my hand back from the sink water due to hot temperatures. b) Water Temperatures During an interview and inspection with the Maintenance Director (MD) #56 on 03/10/25 at approximately 10:30 AM the water temperature was found: -- room [ROOM NUMBER], the sink temperature reading was 128 degrees Fahrenheit. MD #56 stated that once the water had been left running for a while, the temperature would drop. -- room [ROOM NUMBER], MD #56 checked the temperature of the water at the sink in room [ROOM NUMBER] and confirmed a reading of 124 Degrees Fahrenheit. -- room [ROOM NUMBER]: MD #56 checked the temperature of the water at the sink in room [ROOM NUMBER] and confirmed a reading of 118 Degrees Fahrenheit. -- room [ROOM NUMBER]: MD #56 checked the temperature of the water at the sink in room [ROOM NUMBER] and confirmed a reading of 119 Degrees Fahrenheit.

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	515179	A. Building B. Wing	03/18/2025

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Canterbury Center	80 Maddex Drive Shepherdstown, WV 25443

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 50795 Based on observation, record review, and interview, the facility failed to follow a physician's order regarding a prescription for oxygen. Resident Identifier: #22. Facility Census: 59 Findings Include: a) Resident #22 During an interview with Resident #22 on 03/10/25, at approximately 9:43 AM, the resident indicated that she was somewhat hard of hearing. She responded to questions about her care, and expressed that she was happy and content with the facility. The resident was observed to be on oxygen therapy. Inspection of the resident's oxygen concentrator revealed that it was set to deliver 4 liters per minute. During record review performed on 03/10/25 at 1:15 PM a physicians order was revealed The physicians order prescribed oxygen at 2 liters per minute by nasal cannula for Resident #22 Ongoing observation of Resident #22 on 03/1025 at 12:55 PM revealed that the oxygen concentrator was still set at 4 liters per minute. Another observation on 03/10/25 at 2:20 PM revealed that the oxygen was still unchanged and set at 4 liters per minute. A follow-up observation on 03/11/25 at 10:08 AM revealed that oxygen was still being delivered at 4 liters per minute. During an interview with the Assistant Director of Nursing (ADON) at approximately 10:30 AM. ADON confirmed that the oxygen concentrator was set at 4 liters per minute. ADON verified the physician's order and set the oxygen concentrator to 2 liters per minute.

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	515179	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Center	80 Maddex Drive Shepherdstown, WV 25443

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 50551 Based on record review and staff interview, the Facility failed ensure they had sufficient and competent nurse staffing by failing to complete competency evaluations for Nurse Aides. This is true for five of five Nurse Aide charts reviewed. Findings included: Review of staff files on 03/12/25 at 1:57 PM revealed no competency evaluations for the following staff: #28, #1, #2, #33, #63 Interview with Consulting Administrator on 03/12/25 at approximately 2:30 PM revealed that the facility was behind on competencies and that there were no records for competencies in the last year for the following staff: #28, #1, #2, #33, #63

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	515179	A. Building B. Wing	03/18/2025

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 50551 Based on record review and staff interview the facility failed to update nurse staff postings to reflect actual hours worked. This is true for five of five days reviewed. Findings included: Review of staff posting on 03/12/25 at 01:57 PM revealed the following Daily Nurse Staffing Forms were not updated to actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: registered nurses, licensed practical nurses or licensed vocational nurses, and certified nurse aides: 05/28/24 12/18/24 10/21/24 07/05/24 03/05/25 Interview with Consulting Administrator on 03/12/25 at approximately 2:30 PM who acknowledged the Daily Staff Postings were not edited to reflect actual hours worked by direct care staff.

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	515179	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Center	80 Maddex Drive Shepherdstown, WV 25443

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 50801 Based on record review and staff interview, the facility was unable to provide evidence that the attending physician reviewed any irregularities identified by the pharmacist and either accepted or rejected the recommendations. This was true for two (2) of five (5) residents reviewed under the Unnecessary Medications pathway in the Long-Term Care Survey Process. Resident identifiers: #24 and #2. Facility census: 59. Findings include: a) Resident #24: On 03/12/25 10:51 AM During record review: -The Pharmacist Medication Regimen Review for 12/15/24 had not been completed. - The Physician did not respond to the BP Recommendations dated 1/18/20 for taking resident's BP daily. 01/18/2025 Recomendation: - 1/18/2025 Pharmacist Medication Regimen Review (MMR) -Metoprolol directions indicate to hold if SBP < 110 please either add daily BP documentation or remove from directions. If hold direction removed from metoprolol, suggest checking blood pressure and pulse weekly (taking metoprolol, losartan, amlodipine) DON Interview: In an interview with DON on 03/17/2025 at 2:42PM, she stated she was not able to provide a physician response for recommendations for 01/18/25, nor could she provide MMR for 12/15/2024. b) Resident #2: - 11/20/2024 Pharmacist Medication Regimen Review (MMR)- Diclofenac 1% gel to hands, what amount should be used (usually 2GM to upper extremities, 4GM to lower extremities) - Physician response: NONE DON Interview: In an interview with DON on 03/17/2025 at 2:37PM, she stated she was not able to provide an MMR for 12/15/2024 for Resident #2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515179	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 50795 Based on observation, interview and record review, the facility failed to honor, and implement interventions to meet the resident's preferences, as related to the resident's request to have cereal and oatmeal for breakfast. Resident Identifier #52. Facility Census:59. Findings Include: a) Resident #52 During an interview on 03/10/25 at 1:51 PM, resident stated that she had requested cereal and milk for breakfast, but had not received it. Resident's family member stated that she had spoken to the kitchen staff multiple times, and her mother had still not received any cereal with her breakfast. Resident's daughter stated that she would highlight the cereal on her mother's breakfast menu for the next day. On 03/11/25, at approximately 9:15 AM, when interviewed, Resident #52 stated that no cereal had been served to her. Resident #52's family member produced a picture of a bowl of oatmeal on the resident's bedside table. During an interview with Consulting Administrator (CA) #100 at 10:15 AM, CA #100 was notified that the resident had not received her requested cold cereal and milk. CA #100 stated that she would speak to the resident and ensure that the resident's preference would be honored. CA #100 further stated that she was documenting resident's complaint as a grievance, and that the kitchen staff would be educated and notified. A review of Resident #52's Care Plan showed the following notes: FOCUS [Resident] #52is at nutritional risk .[Resident] has a varied po intake and has had protein calorie malnutrition. She is underweight. She hashad a 5% unintended weight loss and is at risk for further weight loss due to her varied appetite. She feeds herself with some tray set up assistance and nursing encourages her to eat. She is on a regular diet with dysphagia advanced texture and regular liquids, house supplements TID which provides sufficient nutrients for healing and weight aintenance. Date Initiated: 02/07/2025 Created on: 12/02/2024 Revision on: 02/25/2025 GOAL (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515179	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Center	80 Maddex Drive Shepherdstown, WV 25443

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident will consume 75-100% of meals and supplements x 90 days. Date Initiated: 02/07/2025 Created on: 12/02/2024 Revision on: 02/26/2025 Target Date: 05/26/2025 IMPLEMENTATIONS Offer/encourage fluids of choice Date Initiated: 02/07/2025 Created on: 12/02/2024 Revision on: 02/07/2025 Record review also revealed that due to the concern with weight loss, resident's physician had ordered the following on 02/07/25 at 7:14 AM: Weigh weekly X 4 and then monthly. Further observation and interview on 03/18/25 at approximately 9:18 AM revealed that resident had not received the requested corn flakes. Inspection of the residents tray ticket revealed the following: [Resident #52] Regular/Liberalized Tuesday (W2-D10) Breakfast 3/18/2025 1 Ea - Hard Cooked Egg 1 Sl - Ginger Peach Coffee Cake 1 Ea - Margarine 1/2 cup - Oatmeal 3/4 cup - Corn Flakes (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515179	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Center	80 Maddex Drive Shepherdstown, WV 25443

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/2 cup - Hash Browns The tray ticket had both the oatmeal, and corn flakes, bolded and underlined to ensure that they were easily noticed. During an interview with RN #47 at approximately 9:22 AM, RN #47 confirmed that the resident had not received the cornflakes. RN #47 stated I frequently have to go to the kitchen and get things for the residents, because the kitchen staff have forgotten to put some items on the tray

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	515179	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 50551 Based on resident council interview and staff interview the Facility failed to provide evidence that snacks were offered to resident at bedtime. Resident identifiers #47, #30, #2, #46, #49 Findings included: a) Residents #47, #30, #2, #46, #49: On 03/11/25 a Resident council meeting was held at 11:45 AM and the following was discussed: Resident #47 reported that staff do not ask if residents want an evening snack. She stated they (staff) will get one if they are asked for but its usually a gram cracker. She reported that she can remember being offered evening snacks on one occasion and was excited to get the treat. Council members agreed that staff do not offer snacks in the evening but they will bring you an oatmeal cake if you ask for one. Cognitively Intact attendees: Resident #47 had a BIMS of 14- lacked capacity to make medical decisions. Resident #30 had a BIMS of 15- had capacity to make medical decisions. Resident #2 had a BIMS of 15- had capacity to make medical decisions. Resident #46 had a BIMS of 15-had capacity to make medical decisions. Resident #49 had a BIMS of 14- had capacity to make medical decisions. During an interview with Dietary manager (DM) on 03/12/2025 at 11:29AM. She reported that ordered snacks are prepared that day prior from list of 3 choices. For residents that do not have snacks ordered by a physician, the pantry is stocked daily with snack cakes. (rotating with one daily Oatmeal cakes, Fudge rounds, and gram crackers) If resident's request a specific snack such as a sandwich or gluten free snack, they can put it in the computer system at least one day prior and it will print out and served daily with the ordered snack. No other snacks are available after the kitchen closes at approximately 7:30 PM daily.

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	515179	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Center	80 Maddex Drive Shepherdstown, WV 25443

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42120 Based on observation, staff interview, and equipment manual review the facility failed to have a clean, sanitized kitchen, store food in the refrigerator, freezer, and dry storage store food in accordance with professional standards for food service safety. The facility also failed to keep the ice machine in safe operating condition. This has the ability to affect all Residents that get their nutrition from the kitchen, also attends food related activities. Facility Census: 61 Findings included: a) Initial Kitchen tour. During the initial kitchen tour with the Kitchen Account Manager on [DATE] at 11:54 AM, an observation found --Walk-in refrigerator - Temperatures not documented -- Walk -in freezer - Temperatures not documented and a large box of cookie dough, open to air. b) Pantry During the resident panty tour on [DATE] at 1:12 PM found the drawer was dirty, littered with sugar, salt, and pepper. The upper cabinet had a box of 12 packs of oatmeal expired in [DATE]. During an interview on [DATE] at 1:20 AM the Infection Preventionist verified that the oatmeal was expired and the drawer was dirty. c) Ice Machines Observation during the kitchen tour on [DATE] at 11:50AM found the ice machine did not have the required water filter as required by the manufacture's guidance On [DATE] at around 1:15 PM, during a tour the Maintenance Director confirmed the ice machine did not have the required water filter.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 42120 Based on observation and staff interview the facility failed to store garbage and refuse in a proper manner. The dumpster area was polluted with garbage and used medical supplies. This has the potential to affect all residents that reside in the facility. Facility census: 61. Findings included: a) Garbage dumpster area An observation on 03/12/25, at 2:57 PM, found the dumpster lids open, and the area around the dumpster was polluted with garbage and used medical supplies. On 03/12/25, at 3:16 PM, during an Interview the Maintenance Director verified the trash / medical supplies on the ground around the dumpster.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42120 50795 Based on observation and interview, facility staff failed to handle, store, process, or transport linens and laundry in a hygienically clean manner, or clean the laundry machine filters. The facility also failed to follow infection control protocols when handling food trays, and trash. In addition, the facility failed to provide residents with hand hygiene before meals. These failed practices allowed for the potential spread of infection throughout the facility. Facility Census: 59 Findings Include: 1) Handling and storage of clean linen (100 Wing, 300 Wing and 400 Wing): a. During an observation of the 100 Wing linen cart on March 10, 2025, at approximately 7:30 AM, Account Manager (AM) #67 was seen replenishing wall boxes with trash bags. While doing this, she pushed a linen cart out of the way with her foot, causing clean linen from the lower rack of the cart to spill onto the floor. AM #67 was observed picking up the spilled linen and placing it back in the cart. However, RN #62 confirmed that the linen should not have been returned to the cart. RN #62 then removed all the linen from the bottom shelf of the cart and placed it in a used linen bag to be sent back to the laundry. At approximately 7:49 AM, the Director of Nursing (DON) approached and mentioned that staff member AM #67 was being educated on the safe and hygienic handling of clean linen. The DON also stated that she was organizing an in-service training for all staff focused on infection control. b. An inspection of the 300 Wing linen cart on 03/17/25 at approximately 12:16 PM revealed a staff person's sweater, a tube of hand lotion, and a can of air freshener placed on top of the clean linen in the cart. RN #53 was notified of the lapse in infection control, and confirmed that personal items were not supposed to be stored in the linen carts. RN #53 promptly removed the items and notified the DON. c. On 03/10/2024 at 6:17 AM During a check in the Linen Cart on 400 wing hall, there was Nystatin topical powder and a tube of Prevent Ointment found on the middle shelf with the clean linens. During a second check of the linen cart in the 400 hall on 03/17/25 at 12:06pm, personal clothing and a bottle of hand sanitizer was found on the second shelf of the linen cart in the clean linens. In an interview on 03/10/2025 at 6:30 AM, with RN #25 acknowledged the medicines were in the laundry cart and stated they were not to be left there and took them away. In an interview with The CNA # 4 on 03/17/25 at 12:20 PM, She stated the clothing was hers, but she did not have it on her body that day and she had placed the bottle of hand sanitizer on the cart so she could use it as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Soiled Briefs Found in trash can in shared Bathroom: On 03/16/25 at 6:50 AM, soiled briefs were found in a trash can in the shared bathroom between rooms [ROOM NUMBERS]. On 03/16/2025 at 12:09PM, during a 2nd check, It was observed soiled briefs in shared bathroom between rooms [ROOM NUMBERS]. In an interview on 03/16/2025 at 12:20 PM with The DON, acknowledged the soiled briefs in the resident's bathroom trash can. She stated she would take care of it. 3) Resident hand hygiene not performed before meals: On 03/10/2025, at 9:00 AM, it was observed, on the 400 hall of the facility, while delivering the residents breakfast trays, CNA # 17 did not offer to wash or sanitize resident #24's hands. In an interview with CNA #17 on 03/10/2025 at 9:05 AM, she stated she did not remember to offer to wash or sanitize resident #24's hands before serving her tray. 4) Dinner food trays left at nurses station overnight: Upon entry to the facility at 5:30 AM on 03/10/2025, It was found that a cart of dinner trays from 03/09/2025 were left in front of the nurse's station overnight. In an interview with the DON on 03/12/2024 at approximately 2:00PM, she stated she was very aware of the dinner trays found at the nurse's station upon survey entry and that they should not have been there. 5) Trash and linen During an observation on 03/10/25 at 5:30 AM the facility had bags of trash and bags of linen on the floor in Hallway 100, 200 and 300. The linen barrels were overflowing in the soiled utility. During an interview on 03/10/25 at 5:46 AM Registered Nurse #9 verified the trash, and linens shouldn't be on the floor. She stated that they just have not had time to take out. 6) Hall 200 lunch tray pass An observation on 03/11/25 at 12:32PM of the noon meal tray pass revealed Nurse Aids placing the dirty plate covers and dirty breakfast trays back on the meal cart with resident lunch trays that were still being passed. An interview with the Infection preventionist verified the dirty items on the clean cart and stated dirty items should never be placed with clean trays. 7) Washing machine filters (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of the laundry room on 03/18/25 at about 12:40 PM found four (4) of four (4) filters on the washing machine were not cleaned daily as required. During an interview with the laundry supervisor on 03/18/25 at about 12:44 PM, she verified the filters are not cleaned daily, she stated the maintenance men clean them when they clean the drains. 50801